

A model of group psychotherapy for persons with chronic mental illness

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Abstract

Significant advances in the pharmacotherapy of many major psychiatric syndromes occurred in the final decade of the last millennium. However, medications neither proved to be an ultimate cure nor did they eliminate the human suffering attendant with these illnesses. As a consequence, a great number of individuals remain significantly impaired by their illness.

Persons with severe and persistent mental illness generally experience their impairments in terms of ordinary living - their quality of life. From an "objective" perspective they experience deficits in financial necessities, housing, transportation, medical and psychiatric care. From a "subjective" perspective they have diminished quality and quantity of social relations and recreational activities. Group psychotherapy, focusing on problems of daily living, of developing and maintaining satisfactory social relations, has the potential for significantly improving patients' quality of life.

Key-words: severe mental illness, group psychotherapy and quality of life, social relations and recreational activities

The Flexible Boundaried Group

A model of dynamically based supportive/adaptive group psychotherapy, labeled the "The Flexible Boundaried Group," [FBG] (McIntosh, Stone & Grace, 1991, Stone, 1996) takes into consideration the dynamics of the chronically ill person as well as those of the group system. The premises of the model highlight patients' general experience of powerlessness in addressing life's ordinary demands and their impaired capacities to form trusting, intimate, and loving relationships inside and outside the family. These deficits manifest themselves in members' defenses and their manner of group participation.

Prominent among patients' defensive operations are withdrawal, isolation, and disengagement, often made conspicuous by their absences from meetings. The flexibly bound model structures the treatment so that following a request that each person attend four successive meetings, patients "contract" with the therapist and the group as to the frequency with which they will attend meetings. Patients are given the option of attending meetings at weekly or monthly intervals, or any combination within this time frame. This strategy enables members to determine their treatment dosage, which to some extent levels the power imbalance between patient and

therapist. Patients are told that they may discuss alteration of their attendance contract and attend more or less frequently if they chose.

Traditionally, group therapists have been imbued with the centrality of group cohesion and regular attendance (Yalom, 1975). In that framework, absences are understood as a communication of resistance, which requires therapeutic attention in order to have an optimal functioning group. Therapists, working within the model of the FBG often find themselves in non-productive power struggles with their patients, a countertransference enactment that often evokes greater withdrawal on the part of both parties.

Use of FBG over a decade has shown that chronically ill patients are generally quite responsible and reliable in keeping with their contract. Moreover, a functional group formation takes place with a core subgroup of regular attendees, and a peripheral subgroup of intermittent attendees (Stone, 1995).

The Therapeutic System

For a therapeutic enterprise to succeed, it needs to be integrated into the overall treatment system. Within the public sector considerable variation exists in providing group treatment. Patients have multiple needs, and administrators are responsible for attending to these needs, often with limited budgets. The group program represents only a single therapeutic component within the system. Thus efforts to initiate and maintain a group program require attention to the needs and philosophy of the particular clinic system. Collaboration with case managers and administrators is essential in order to ferret out the covert agendas, policies and impediments to a successful program.

Example: For many years a clinic group program suffered from an apparent paucity of referrals. Exploration of resistances at various administrative or therapist levels did not provide adequate understanding of the difficulty. Only during a meeting with the Clinic Director was it learned that the primary funding agency (the regional mental health board) mandated specific amounts of individual, family and group treatments and failure to provide the predetermined quota meant a reduction in funding. The director noted that the prior year, the clinic had "overused" group and had not met the quota of individual services, which had necessitated the administrator to return money to the funding agency.

The example illustrates the influence of state or federal policies, often unknown to the person directly providing service.

A working alliance with administrators is essential in order to assure clinic support for many requirements of a group program. Space for waiting areas and meetings differs from that for dyadic treatment. The extent of productivity credit (i.e., the amount of patient care each clinician must provide) and "paper work" is essential, since some administrative requirements and policies prove discouraging to clinicians. One solution to adjusting productivity credit is to simply give credit for 1.5 times the duration of the meeting. Another solution would be to give a predetermined amount for each patient in attendance: e.g., a credit of .3 units per person would give a group

with 5 persons in attendance 1.5 units of credit. This system rewards clinicians who maintain larger groups.

Arrangements for supervision and on-going educational opportunities are essential to prevent staff burnout and abandonment of the project.

Group Goals

The fundamental goals of the group are to prevent relapse and to improve patients' quality of life. Members are to use the group to address symptoms, which might include hallucinations or paranoid thinking, problems in everyday living and the impact of their illness upon their lives. As described by Kanas (1996), specific permission to address psychotic processes has the potential for diminishing patients' self experience of difference and strangeness. However, the main thrust of treatment is exploring patients' social relationships as they emerge in discussions of problems in everyday living and in examining the impact of their illness upon their life. The difficulties are also reflected in the manner in which members establish relationships within the group. Within group interactions (transferences) are best examined only after a solid working alliance is established. Exploration of historical antecedents of disturbed and disturbing interactions is generally eschewed.

The emphasis on understanding patients' faulty relationships, does not militate against discussion of medications. Indeed, most group members receive medication, and certainly an aspect of their illness is the meaning and experience of taking medicine. Moreover, interactions in the group provide opportunities to observe "members in action" which may provide information regarding medication requirements. Therapists need to appreciate both the real and the metaphorical level of patients' discussion of medicines as potential information about the state of their relationships.

The Group Format

Prior to forming the group, clinicians should establish the mundane but essential elements in conducting treatment. They need to set day, time, and place. Most often these once weekly groups are held during the daytime. In general patients are either unemployed, or work part time, and they prefer daytime and daylight hours. A group might be held prior to the noon hour, which could encourage member socialization over lunch (see below for boundary issues).

The sessions are usually briefer than traditional outpatient psychotherapy groups, ranging from 45 to 75 minutes in duration. At times, the briefer sessions seem insufficient particularly when there are eight or more members present. Strohm-Cohen has suggested that when attendance reaches this level, an extra ten minutes might be added to the session (Shtrom-Cohen, C, personal communication [2000]). In many settings arrangements for medications are made with a psychiatrist to be present at the end of the sessions, when he/she can provide medications and consult with the therapist. Medications can be openly discussed in front of other members, who at times may be very helpful in addressing resistances to taking medicine.

Additional advantages with this structure are the ease of communication between therapist and psychotherapist, and the elimination of an extra clinic visit for the patient.

Getting the Group Together

Patient Selection: Although diagnosis alone is not the only criterion for inclusion, diagnosis represents a starting point. Bachrach's (1988) schema of the three D's represents a more inclusive set of criteria: diagnosis, duration and disability. The degree of impairment (disability) within the diagnostic categories often is the determining factor for inclusion.

The usual diagnostic categories from which patients are drawn include the major psychotic illnesses of schizophrenia and schizoaffective disorders, mood disorders including bipolar illness, major depression and dysthymia. Chronic anxiety disorders and many personality disorders are also well represented in this population. Patients with substance abuse that has been adequately treated (i.e., detoxification and some period of abstinence) may also be candidates. Mild organic impairment is not a contraindication for group participation.

Exclusion criteria are few. Nevertheless, certain individuals are not good candidates for a FBG. Persons experiencing their initial episode of a psychotic illness require more intensive support and education than can readily fit into a FBG group. Persons experiencing an acute crisis (psychotic or affective decompensation, marital dissolution, a recent death) should have their candidacy deferred until the crises has been resolved. These individuals require more personal attention than can be provided by the group. Patients with concomitant major alcohol or substance abuse require more specialized dual-diagnosis groups

It should be obvious that patients who do not want to enter groups should not be "forced" to join. Many individuals overtly resist entering a group. A number of others may equivocate. Eager clinicians pressure individuals to join, only to be disappointed when they never appear or drop out after only a few sessions (Klein & Carrol, 1986). Thus therapists need to carefully monitor their contribution to the evaluation interviews to determine the extent of any pressure they may be applying. Certainly, some individuals wish for the clinician to "convince" them of the value of group therapy, and they are successful in their group career. Hard and fast rules can not be laid down as guidelines for the selection process.

Patient Recruitment: At first glance, recruiting patients for group treatment would seem a simple task. Yet, as noted above, patients often are reluctant to enter group treatment. Similarly, therapists may be reluctant to share or give up patients to a group. In my opinion, it is essential that therapists recruit patients for their group from their own individual case roster. This provides first hand experience of the tasks involved, and helps the clinician remain sympathetic with the difficulties others may have in referring potential members. With that caveat, the following list provides a rough hierarchy for patient referrals (Stone, 1996).

1. Therapist's own caseload

2. Colleagues caseload
3. Clinic intake (entry) system
4. Waiting list groups
5. Staff review conferences
6. Transfers from departing therapists
7. Continuing education seminars
8. Posted notice

Examination of this list highlights the personal nature of patient recruitment. A clinician's own cases and those of his close colleagues often are the most fruitful source for obtaining patients. A positive working relationship with co-workers and administrators within the clinic system enable clinicians access to potential members within the usual format of clinic administrative, supervisory and teaching activities. Alliances with intake workers increase the potential for routing referrals to group rather than dyadic treatment. If a clinic requires patients to wait for assignment following intake, a "waiting list" group may be an excellent introduction to group treatment and serve to increase the referral base (Stone and Klein, 1999).

Patient preparation: All patients should be privately interviewed prior to entry into a group. The therapist uses the preparatory interview(s) to:

- 1) Obtain a history of the patient and his/her illness and further assess appropriateness for group
- 2) Establish a beginning alliance that helps sustain them through the initial treatment period
- 3) Address the patient's treatment goals
- 4) Explore the patient's anxieties about entering the group
- 5) Provide opportunities to give specific information about the group
- 6) Review the group agreement

This is a substantial amount of work, and it often can not be accomplished in a single interview. Clinic records of new referrals may vary considerably in the amount of information they contain, but it behooves a clinician to personally explore a patient's history, motivation and anxieties about entering a group.

The clinician will do well to have an initial contact with the patient on the phone in order to arrange the assessment/preparatory meeting(s). For newly forming groups, such meetings are best done at the proposed meeting time which provides an opportunity to determine the patient's ability or willingness to attend at that specific time. If more than one session is necessary, then another time might be arranged for the second meeting. Certainly such arrangements are not possible in all circumstances, (i.e., new patients evaluation for an ongoing group) but for forming a group, it seems optimal.

Determining goals and motivation for group treatment is often problematic. Patients may say they come to the group at the recommendation of their therapist, an intake worker, the hospital doctor, or they were just sent. Exploration of patients' experiences in hospital groups, their perceptions of benefits or drawbacks, may help patients' articulate goals. Generalizations such as providing help with problems of

everyday living can be examined in relation to patients' obtaining help with difficulties within the family, establishing and maintaining friendships, or exploring readiness to volunteer or work. Patients who only wish to attend group to have their medication refilled are poor candidates for this treatment modality.

Patients should be provided time to explore their anxieties about entering a group. A useful tactic that serves to allay anxiety is reviewing with patients how they have entered other group situations (church, school, work) and what strategies they have employed to manage the entry process. The clinician should be open to questions about the group (see agreement) and provide the necessary information such as the purpose and the general composition of membership (members have a chronic illness and they are working on problems outlined in the group goals) time, duration, and frequency of sessions.

The group agreement: The group agreement serves to help define the patients' and therapist's tasks and responsibilities. It creates a structure and points towards useful group norms. It is not a set of rules. Rather it contains principles that help make the group therapeutic.

1. Establish treatment goals. This may be a general goal of helping with social relationships or learning new ways to manage symptoms or problems in every day living.

2. Agree to attend the group in accord with the agreement. After the fourth session the patient will determine the frequency with which he/she will attend

3. Put feelings into words, not into action. Affectionate as well as aggressive acts are included in this element of the agreement. Verbal attacks are also construed as "actions."

4. Collaborate with administrative requirements. Clinics often require completion of forms and financial assessments that seem burdensome, yet may be necessary for the clinic's funding sources.

5. The therapist will work to help the patients understand their problems and will intervene in ways that he/she believes will be helpful to the individual and the group.

6. Preserve confidentiality. Members are told that if they discuss their group experience, it should be done in a fashion that no member may be identified.

This agreement differs from one that is utilized for more traditional groups. It highlights flexibility of attendance (FBG) and empowers patients to choose their treatment dosage following an initial period of regular attendance. Moreover, the agreement does not instruct patients to explore intragroup relationships and extragroup contacts. Based on prior experiences, patients are leery of exposing feelings directly and only after a substantial period of time and development of trust can they begin to approach interpersonal relationships within the group. Extragroup contacts are almost a norm. Members may live in the same community and they naturally will subgroup - they exchange phone numbers and call one another, or they come together on the bus. In my experience extra group socializing is seldom a problem, but it needs to be discussed as openly as possible in the group without creating an unworkable sanction.

The Therapist's Tasks

The therapist creates the atmosphere and tries to set the tone for the group. The process of selection, preparation and the group agreement are the initial steps in this process. However, the patient mix and each individual's capacity for interaction are powerful factors in creating the group climate. The clinician is alert to creating an emotionally safe group. This can be addressed by the therapist striving to be predictable, dependable and reliable (Goldberg, 1999). The following tasks overlap, but are separated for heuristic purposes (Stone, 1996, p. 99)

1. Managing boundaries
2. Linking members
3. Identifying themes
4. Managing affect
5. Handling metaphors
6. Promoting problem solving
7. Promoting self-understanding.

Managing Boundaries: A therapist's primary task is to manage both external and internal group boundaries. The agreement defines external boundaries through membership, attendance requirements and members' relationship to the clinic; it addresses the nature of information or data that patients are to bring to the group. Internal boundaries define the relationship among members and with the leaders (i.e., put feelings into words not action). Ultimately, relationships are a result of the interaction and the unfolding process that is constructed by all present.

Linking members: Typically individuals enter treatment in a state of relative isolation. Beginning efforts to feel comfortable are through ordinary inquiries - where do you work, live, are you married, etc.? Members' attempts to find similarities can be expanded by the therapist in noting similar emotional states or attitudes. By building pairs or subgroups the clinician prevents development of singletons or isolates and increases members ability to tolerate differences and conflict (Agazarian, 1997). Subgroups form building blocks to increasing allegiance to the whole group.

Identifying themes: In many sessions (particularly those involving a newcomer or a missed meeting, i.e., boundary crossings) a clear theme emerges. By identifying a common thread the clinician enhances a sense of belonging and working together. Patients who express "negative" attitudes also are responding to the theme, and they can be linked to the whole as a divergent subgroup.

Managing affect: Dynamically oriented clinicians attend to affects as the central force moving or inhibiting the group process. For many chronically ill persons direct expression of anger or rage is disorganizing (see the extensive literature on expressed emotion). These feelings can be managed in displacement or metaphor. Similarly, positive affects (include a sense of closeness or intimacy) may be frightening because of prior experiences of rejection or empathic failure. Attention to the treatment process will inform the clinician of the meaning of these affective experiences.

Patients are exposed to multiple feelings and beginning efforts to identify and label emotions may enable members to tolerate and live with a broader range of experiences.

Handling metaphors: Communications within a group are often expressed through metaphors. Discussions of authorities (police, teachers, etc.) may be communications about the therapist. Similarly, peer stories may be about relationships among the members. Therapists process these "stories" as potential information about the state of group transferences. A difficult decision follows, whether or not to make a transference interpretation or work first within the metaphor (Katz, 1983). These decisions need not be mutually exclusive. Therapeutic work can take place within the displacement prior to interpreting the material into the group process

Example: A group had experienced a traumatic session in which a patient, in the process of a psychotic decompensation, accused another member of wanting to kill him. The discussion persisted for the entire last half of the meeting. The following two meetings were tensely inhibited, but the paranoia was not effectively addressed. June began the next session by relating that her eight year old cat had been declawed. The members promptly became affectively engaged. They indicated that cats could still catch mice, they wouldn't tear up furniture, the pain from the procedure was short lived; and how cute little kittens were. The metaphorical meaning seemed clear - the patients were finding a way of communicating the diminution of their infighting. The therapist merely commented about people being pleased that furniture would not be damaged. The metaphor was not translated. Eventually, when the heat cooled down, the patients were able to address the episode and some of the meanings for the participants.

Promoting problem solving: Many of the issues that chronically ill persons bring to the group are linked to tasks of daily living: housing, food, dealing with government bureaucracy, etc. Assistance and advice (often best obtained from others who may have first hand experience) can be very helpful and may serve to solidify attraction to the group. Attention to the metaphorical and dynamic meanings can be postponed until work at the "real" level is accomplished.

Promoting self-understanding: Chronically ill individuals are capable of gaining self-understanding, particularly focused on here-and-now within group interactions. Insight may be extended to include current life situations, but extensive exploration of "genetic" bases for disturbed interpersonal relationships generally is not productive. On occasion, patients will explore their external or past behaviors before risking examination and understanding current in-group transactions (Stone, 1998)

Taken together the therapist's tasks and responsibilities serve to promote optimal conditions for members to stabilize themselves, to begin work towards improving relationships and achieve a degree of self understanding.

The Group Process

The opening phase: Most chronically ill persons exhibit considerable caution upon entering a group. The clinician can allay a small amount of anxiety by having the

patients introduce themselves by name and then reviewing the agreement (this is best repeated when a newcomer enters the group) . This is followed by the "instruction" that members may proceed in any way they choose. However, the opening phase can be slow moving, with little patient self-revelation. Indeed, it may seem that only the therapist exists as members focus on the clinician's verbal and nonverbal communications. Linking behaviors among members are limited. Members may focus on a single individual's problems as a way of determining safety, and thereby minimize their engagement. Attendance may be uneven and dropping out is not unusual. Physical complaints, which reflect the widespread medical illness of the seriously mentally ill population, are used as communication of distress, as ways of linking, and as ways of gaining attention.

Example: The group began with a discussion by several members witnessing Grace, a member, having a seizure in front of the clinic. There was a brief discussion of their not knowing what to do. Jack followed by beginning to tell of watching his sister have a seizure, but he was interrupted twice. He irritably completed his story, but then proceeded to relate that he had lost his driver's license because of his poor eyesight, secondary to diabetes. Bill said that he could only go two minutes on a treadmill test for his heart disease before he became short of breath. He added that his doctors had stopped his nicotine skin patches and he had resumed smoking. During the remainder of the session the patients focused on their desire for and difficulty in giving up smoking.

Comment: The multiple levels of meaning for this discussion often leave the clinician uncertain how best to intervene. Certainly the medical complaints are serious, yet there is little exchange or interest in one another's illness or the impact of the illness upon their lives. Moreover, the anxiety stirred by witnessing the seizure may have led to regressive competition for attention. The discussion of smoking may represent ambivalence regarding the illness and a statement of oral needs.

Considerable activity on the part of the therapist is useful in this phase in helping bond members. A clinician's extended silence, waiting for patients to interact, may be counterproductive, because members become absorbed in their own regressive and often disturbing fantasies. The therapist through linking individuals and identifying themes helps move the group into the next phase

Intermediate Phase: In this phase members begin to more consistently interact with one another. One characteristic, however, is parallel talk - as illustrated in the above example. Each member associates to his/her own concerns and there is little overt interest in the others. In this phase, members begin to acknowledge attachment to the group, and will express interest in absences or interruptions. However, the therapist's direct inquiry into such events (boundary alterations) often is met with either compliant acceptance of efforts to examine emotions or with denial. The subsequent associations, recognized as potential metaphors, will expose members' less conscious responses.

The therapist's task is to continue linking members, particularly at an affective level. Feelings of neglect, loss or abandonment, particularly by family members, are

common themes, and provide segues to identifying common emotional states. Moreover, metaphors may be tentatively translated into the group with the caveat that clinicians appreciate patients' reluctance to directly address conflict.

Advanced stage This stage is characterized by increased give and take among the members. The quality of interaction evolves where members are genuinely concerned about one another. Sexual relationships and the meaning of intimacy intermittently become discussion topics. In this context, members will ask questions, pursue ideas, and engage in animated discussion. This stands in marked contrast to meetings characterized by relatively lifeless interchanges and extended monologues.

Patients can explore some of the intragroup tensions, and they are more willing to acknowledge stresses related to interruptions and a therapist's absence or loss (an annual occurrence in most training settings).

Example: Members of this long-term, co-led group struggled with their feelings about imminent departure of the senior staff therapist (Dr. Senior) for an extended summer vacation. The new male trainee had been present for six weeks and was beginning to more comfortably interact with the group. About half the members were diagnosed with schizophrenia (S), and the other half with affective disorders (A), primarily chronic depression.

The session began with Mary (S), inquiring about a member who had stopped coming to sessions. Dr. Senior replied that she had said she could no longer obtain transportation. And would not be returning. Janice (A), who attended bimonthly, said that she was sorry that the prior therapist had left. There was brief discussion that Dr. Departed (a woman) had remained with the group two years and would be missed. Will (S), the senior member asked if everyone knew that there had been announcements of severe thunderstorms for later in the day, and he hoped everyone would get home before the storm. This led to a discussion of concerns about the excessive heat and heat related deaths.

Mary, seemingly changing the subject noted that the plant in the room had a dead leaf. This led to an animated discussion involving all but one member about their relative ability to care for house-plants; success required experience. Rose (A) associated to her two fish. After the first one died, the other soon expired of "loneliness." Dr. Senior suggested that the topics of caring for plants and fish may also reflect concerns they might be having as he, the experienced leader would be on vacation for three weeks and they would be with their new therapist, Dr. Junior.

The responses within the group included wishing Dr. L well on his vacation, talking about his longevity with the group, and then shifting to the difficulty in working with new doctors in the various clinics they attended. The meeting ended with comments to Janice of amazement of her marriage of 61 years, and how wonderful it was to be married so long.

The theme of loss and replacement, stimulated by the senior therapist's forthcoming vacation were expressed in metaphors of weather and death followed by value of experience. Interpretation helped patients deal with the immediate concerns (they will ordinarily not express anger) and express their ambivalence safely in a displacement.

At times, members are capable of developing insight into their here-and-now relationships (Stone, 1998).

Termination: Saying goodbye is a difficult process for chronically mentally ill individuals. Many patients simply disappear from treatment without notice. They may move from the area where they are eligible for services, become too physically ill to attend, or leave when they have felt criticized or misunderstood. The net result is a significant attenuation of the termination process. Members may recall abrupt losses from earlier in their lives, but seldom do they directly express their loss in the here-and-now. Surprisingly, however, grief over such losses may emerge months or years later.

Comment: The outline of developmental phases should not be taken as being traversed in a specific time frame. Groups may remain in any phase for extended periods of time (up to years) depending on the level of members' functioning. An extended time frame may be necessary for productive work may take place as members struggle to overcome emotional trauma and presumed alterations in brain structure.

When a group moves from one stage to another some individuals may emotional remain within the preceding stage (Arsenian, Semrad & Shapiro, 1962). These members serve a convenient nidus for regressive shifts under stresses occurring within the group framework. . Boundary alterations, as exemplified by membership changes or interruptions in sessions, may evoke regressive forces. A patient suffering a decompensation may evoke anxiety and regression within the entire group. Group development is a guideline for therapists, not a goal per se.

Countertransference and Difficult Problems

Clinicians assuming leadership responsibility for groups of patients with severe and persistent mental illness are well served to have prior experience with similar individuals in a dyadic format. Therapeutic expectations for cure require considerable modification. Even hopes that patients can successfully find part time or volunteer work may be frustrated. Members' difficulties in relating try even the most patient clinician, who often experiences a variety of dysphoric feelings. Boredom, loss of interest, or memories of fun or difficult events often cross his/her mind. Therapists' boundary crossings are not uncommon: e.g., slight tardiness in beginning the meeting, neglecting to announce forthcoming absences in the usual manner. The result of the stress upon the therapist alters his/her capacity to remain empathic, hear metaphors, track the process, or listen to the emotional subtext rather than remain "concretely" preoccupied with specific problems.

Maintaining a therapeutic atmosphere in the group can be a frustrating task. Difficult individuals contribute and often clinicians harbor a fantasy of getting rid of one or two members - sometimes by violent means. Guilt and shame follow. Sometimes patients threaten the group safety. They may carry a concealed gun or knife. If the clinician discovers this, the patient should be asked to either give up the weapon or leave the clinic. Occasionally patients arrive intoxicated (not limited to alcohol) and

if they are quiet they may remain. If not, he/she should be asked to leave (also keeping in mind the safety of the intoxicated person). The atmosphere may also be threatened by extragroup contacts among members. In the main this is not a problem, but there are circumstances in which those who are meeting outside the group get into conflict leading to dropping from the group. Of course, to the best of one's ability, the therapist should try to keep communication open about such contacts among members.

An additional stress for clinicians are patients' requests for services outside of the group session, e.g., phone calls, contact with family or other care givers, or decisions about visiting hospitalized members. Moreover, collaboration with case managers and administrators (i.e., changes in paper work requirements) can be frustrating and often require attention

The antidote to such experiences is provision of regular supervision/consultation, and opportunities for additional education. Optimally, these educational/supervisory experiences take place in a group format, where as an antidote to therapists' experience of isolation, clinicians can engage in a supportive group experience. Videotaping of groups and review of sessions is time consuming, but clinicians' interest can be piqued through examination of microscopic processes that enable them to see previously unrecognized sequences, dynamics and subtle changes in how patients engage one another. This should be tempered with the recognition that for many chronically ill persons, "insights" do not easily stick, but require reinforcement, and regression under stress is to be expected.

Nevertheless, over extended periods one can observe a stabilization and improvement in members' ability to relate. Patients seem to have increased periods of reporting positive interactions and ability to garner support under stress. The task is ongoing.

Concluding Thoughts

Studies assessing the quality of life for patients with persistent and severe mental illness are sparse. The complexity of studying heterogeneous groups, such as described in this paper are daunting. Yet these groups represent the ordinary clinical experience of most practitioners engaged in caring for these needy and deserving individuals.

Patients diagnosed with schizophrenia or schizoaffective disorder were found to have a decreased relapse rate when receiving pharmacotherapy combined with group therapy compared with a control condition (Herz, Lamberti, Mintz et al, 2000). However, a recent meta-analytic review of controlled outcome studies found group treatments for schizophrenic patients to have a lower treatment effect (relapse prevention) than other psychosocial therapies such as individual treatment, psychoeducational intervention (Mojtabai, Nicholson, & Carpenter 1998). This study focused on relapse and not quality of life.

Returning to my initial premise that broadly defined social relations operationalized as patients' ability to develop and maintain satisfying personal relationships, is the particular advantage and indeed the mainstay of group treatment. Long term this

should not only diminish relapse rates (not only of psychotic symptoms, but of depression, and anxiety disorders as well) but lead to a more satisfying adjustment and understanding of their life.

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